Dr. Calloway Jr.

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 20777

FILED JUL 8 1957

Registration District No. 128 Primary Registration District No. 2002 Registrar's No. 589

1. PLACE OF DEATH a. COUNTY Greene b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Inside Limits Yes X No ☐ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Hosp. — Length of stay in 1b: 1 Year	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene c. CITY OR TOWN Springfield 0394 — Inside Limits Yes X No ☐ d. STREET ADDRESS (If outside, give location) 1810 W. Webster — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print)	First: OLLIE	Middle:	Last: SMITH	4. DATE OF DEATH	Month: July	Day: 2	Year: 1957
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐	8. DATE OF BIRTH: Feb. 24 1873	9. AGE (In years last birthday): 84	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: W.H. Williams		14. MOTHER'S MAIDEN NAME: Nancy McClure	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: No	17. INFORMANT: G.L. Smith Address: Springfield, Mo.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ~~Le~~ Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Arteriolonephrosclerosis — 6 years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 442X

19. WAS AUTOPSY PERFORMED? YES X NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION / COUNTY / STATE	

21. I attended the deceased from June 27, 57, to July 2 1957 and last saw her alive on July 2 57

Death occurred at 5:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: L D Calloway Jr (Degree or title): MD	22b. ADDRESS: Springfield, Mo	22c. DATE SIGNED: July 3, 57	
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 7/3/57	23c. NAME OF CEMETERY OR CREMATORY: Protem Cemetery	23d. LOCATION (City, town, or county) (State): Protem, Mo.
24. FUNERAL DIRECTOR ADDRESS: Forsyth Funeral Home Forsyth, Mo.	25. DATE RECD. BY LOCAL REG.: 7-5-57	26. REGISTRAR'S SIGNATURE: Edith Williamson	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed H. L. McCann

Licensed Embalmer No. 27

P. O. Addre[illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.